EXHIBIT A

Personally Accepted
On behalf of CHLIC
8/8/22 9:45 am

SUMMONS

Attorney(s) Callagy Law, PC
Office Address 650 From Rd., Ste. 240
Town, State, Zip Code Paramus, NJ 07652

Telephone Number 201-889-6119
Attorney(s) for Plaintiff
Monmouth County Pain Management

Plaintiff(s)

vs.

Cigna Health and Life Insurance Company, et al.

Defendant(s)

Superior Court of New Jersey

Middlesex County
Law Division
Docket No: MID-L-2063-22

CIVIL ACTION SUMMONS

From The State of New Jersey To The Defendant(s) Named Above:

The plaintiff, named above, has filed a lawsuit against you in the Superior Court of New Jersey. The complaint attached to this summons states the basis for this lawsuit. If you dispute this complaint, you or your attorney must file a written answer or motion and proof of service with the deputy clerk of the Superior Court in the county listed above within 35 days from the date you received this summons, not counting the date you received it. (A directory of the addresses of each deputy clerk of the Superior Court is available in the Civil Division Management Office in the county listed above and online at http://www.njcourts.gov/forms/10153_deptyclerklawref.pdf.) If the complaint is one in foreclosure, then you must file your written answer or motion and proof of service with the Clerk of the Superior Court, Hughes Justice Complex, P.O. Box 971, Trenton, NJ 08625-0971. A filing fee payable to the Treasurer, State of New Jersey and a completed Case Information Statement (available from the deputy clerk of the Superior Court) must accompany your answer or motion when it is filed. You must also send a copy of your answer or motion to plaintiff's attorney whose name and address appear above, or to plaintiff, if no attorney is named above. A telephone call will not protect your rights; you must file and serve a written answer or motion (with fee of $175.00 and completed Case Information Statement) if you want the court to hear your defense.

If you do not file and serve a written answer or motion within 35 days, the court may enter a judgment against you for the relief plaintiff demands, plus interest and costs of suit. If judgment is entered against you, the Sheriff may seize your money, wages or property to pay all or part of the judgment.

If you cannot afford an attorney, you may call the Legal Services office in the county where you live or the Legal Services of New Jersey Statewide Hotline at 1-888-LSNJ-LAW (1-888-576-5529). If you do not have an attorney and are not eligible for free legal assistance, you may obtain a referral to an attorney by calling one of the Lawyer Referral Services. A directory with contact information for local Legal Services Offices and Lawyer Referral Services is available in the Civil Division Management Office in the county listed above and online at http://www.njcourts.gov/forms/10153_deptyclerklawref.pdf.

s/ Michelle Smith
Clerk of the Superior Court

A True Copy
Attest:
Process Server
Sandra Yabe

DATED: 08/02/2022

Name of Defendant to Be Served: Cigna Health and Life Insurance Company

Address of Defendant to Be Served: 900 Cottage Grove Road Bloomfield, CT 06002

MONMOUTH COUNTY
SUPERIOR COURT
PO BOX 1270
FREEHOLD NJ 07728

TRACK ASSIGNMENT NOTICE

COURT TELEPHONE NO. (732) 358-8700
COURT HOURS 8:30 AM - 4:30 PM

DATE: JULY 29, 2022
RE: MONMOUTH COUNTY PAIN MANAGEME VS CIGNA HEALTH A
DOCKET: MON L -002063 22

THE ABOVE CASE HAS BEEN ASSIGNED TO: TRACK 2.

DISCOVERY IS 300 DAYS AND RUNS FROM THE FIRST ANSWER OR 90 DAYS FROM SERVICE ON THE FIRST DEFENDANT, WHICHEVER COMES FIRST.

THE PRETRIAL JUDGE ASSIGNED IS: HON KATHLEEN A. SHEEDY

IF YOU HAVE ANY QUESTIONS, CONTACT TEAM 003 AT: (732) 358-8700 EXT 87871.

IF YOU BELIEVE THAT THE TRACK IS INAPPROPRIATE YOU MUST FILE A CERTIFICATION OF GOOD CAUSE WITHIN 30 DAYS OF THE FILING OF YOUR PLEADING.
PLAINTIFF MUST SERVE COPIES OF THIS FORM ON ALL OTHER PARTIES IN ACCORDANCE WITH R.4:5A-2.

ATTENTION:

ATT: LORI B. SHLIONSKY
CALLAGY LAW
650 FROM RD
STE 565
PARAMUS NJ 07652

ECOURTS

CALLAGY LAW, P.C.
A Limited Liability Company
Lori B. Shlionsky (Bar Id. 205322017)
Mack-Cali Centre II
650 From Road, Suite 240
Paramus, New Jersey 07652
Phone: (201) 261-1700
Fax: (201) 549-6236
E-mail: lshlionsky@callagylaw.com
Attorneys for Plaintiff, Monmouth County Pain Management, Dr. Brian Bannister

MONMOUTH COUNTY PAIN MANAGEMENT, DR. BRIAN BANNISTER A/S/O PATIENT PATRICIA W.	**SUPERIOR COURT OF NEW JERSEY LAW DIVISION: CIVIL PART MONMOUTH COUNTY**
Plaintiff,	**DOCKET NO.:**
v.	**CIVIL ACTION**
CIGNA HEALTH AND LIFE INSURANCE COMPANY, and SETON HALL UNIVERSITY,	**COMPLAINT**
Defendants.	

Monmouth County Pain Management, Dr. Brian Bannister ("Provider") on assignment of Patricia W. ("Patient" or "Principal") (collectively "Plaintiff") by way of Complaint against Cigna Health and Life Insurance Company and Seton Hall University ("Defendant(s)"), asserts:

THE PARTIES

1. For all relevant times herein, Plaintiff is and was a healthcare provider in the State of New Jersey whose principal place of business is 432 Ocean Blvd., Unit 201, Long Branch, NJ 07740.

2. Upon information and belief, Defendants were present and engaged in significant activities in the State of New Jersey to sustain this Court's exercise of *in personam* jurisdiction.

3. Venue and Jurisdiction is proper in the Monmouth County Superior Court because the Plaintiff resides in Monmouth County.

ANATOMY OF THE CLAIM

1. Upon information and belief, at all material times Principal had health insurance through her employer, Seton Hall University, which provided health insurance benefits via a group insurance contract administered by third-party Cigna Health and Life Insurance Company.

2. At the time of the subject surgery Principal's selected medical benefit option was the Open Access Plus Medical Benefits, OAP1. See **Exhibit A**.

3. Patient presented to the operating room of the Hudson Regional Hospital, located at 55 Meadowland Parkway, Secaucus, New Jersey 07094 on September 11, 2019, with severe radiating back and leg pain with neurologic claudication brought on by severe spinal stenosis at L3-L4, L4-L5, and L5-S1. See **Exhibit B**.

4. On September 11, 2019, Dr. Brian Bannister, medical provider with Monmouth County Pain Management, provided medically necessary and reasonable services to Patient. Id.

5. Patient underwent an L3 laminectomy, an L4 laminectomy, an L5 laminectomy and a partial S1 laminectomy on September 11, 2019. Id.

6. At the time of the subject surgical procedure, Dr. Brian Bannister, medical provider with Monmouth County Pain Management was not participating in the network of providers associated with the benefits provided by the plan. See **Exhibit C**.

7. The subject complex spinal surgery performed by the Out-of-Network provider Dr. Brian Bannister, medical provider with Monmouth County Pain Management, qualifies as a covered medical procedure pursuant to the terms of the Summary Plan Description (hereinafter "SPD"). See **Exhibit D**. (Page 19 of SPD).

8. The bill for this service, submitted to Defendant by way of health insurance claim forms (hereinafter "HICFs"), was $200,900.00. See **Exhibit E**.

9. On April 2, 2020, Defendants allowed reimbursement for these surgical services rendered by Dr. Brian Bannister in the total amounts of $623.88. See **Exhibit C**.

10. This represents an underpayment of approximately $26,585.82, considering applicable pay rates.

11. The Plan's SPD allows for reimbursement to out-of-network providers such as Dr. Brian Bannister of Monmouth County Pain Management pursuant to the Maximum Reimbursable Charge. See **Exhibit D**.

12. The SPD defines the Maximum Reimbursable Charge as:

> The Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or
>
> A policyholder selected percentage of a schedule developed by the Insurance Company that is based upon the methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. (The Insurance Company may apply a rate higher than the Medicare allowable rate.)
>
> A Medicare based schedule will not be used in determining the Maximum Reimbursable charge for:
>
> - Charges made by providers not participating in Medicare or that do not submit their Medicare ID with the claim;
> - Covered Services which Medicare has not established a rate; and
> - The following Covered Services until such time as the Insurance Company has implemented a Medicare-based schedule for them: certain ambulance services, treatment of end state renal disease, Home Health Care, Skilled Nursing Facility, and inpatient rehabilitation.
>
> In these situations:

- The Maximum Reimbursable Charge is determined based on the lesser of:
    - The provider's normal charge for a similar service or supply; or
    - The 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.

See **Exhibit D** (SPD at page 16).

13. The medical provider, Dr. Brian Bannister, of Monmouth County Pain Management did not submit a Medicare ID with the claim associated with the instant surgical procedure. See **Exhibit E**.

14. Because this claim was not submitted to Medicare or with any Medicare ID, the applicable pay rate for this claim is the "80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company." See **Exhibit C**.

15. Plaintiff disputes the calculation Defendant used to establish the allowed reimbursement for CPT codes 63048 (3 times), 63047 and 76000, wherein Defendant reimbursed Plaintiff $75.50 (3 times) and $397.38 and $0, respectively, far below the Plan's reimbursement rate. See **Exhibit C** and **Exhibit D** at Page 16.

16. Plaintiff appealed Defendant's determination on multiple occasions.

17. In fact, pursuant to Defendant's correspondence of June 12, 2020, plaintiff has exhausted the appeals process. See **Exhibit F**.

18. Thus, Plaintiff has exhausted all administrative remedies.

19. Dr. Brian Bannister of Monmouth County Pain Management, proceeding on an Assignment of Benefits from Patient, brought suit.

20. Accordingly, Plaintiff brings this action for the recovery of the balance of benefits due to Principal under the Plan for the treatment rendered to him by Dr. Brian Bannister.

FIRST CAUSE OF ACTION
(Breach of Contract)

1. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

2. As a result of the foregoing, Defendants provide health insurance benefits to the insured Patient and through their actions breached the contract with the Patient.

3. As a result of Defendants actions, Plaintiff has been damaged in an amount of $26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

SECOND CAUSE OF ACTION

(Unjust Enrichment)

4. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

5. Defendant was unjustly enriched at the expense of the Plaintiff.

6. Plaintiff provided services to Patient, the Defendants insured, and the Plaintiff was underpaid pursuant to the health benefit plan.

7. As a direct and proximate result of the Defendant's actions and unjust enrichment, Plaintiff has suffered, and will continue to suffer, substantial monetary damages.

8. As a result of Defendants actions, Plaintiff has been damaged in an amount of $26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

THIRD CAUSE OF ACTION
(Promissory Estoppel)

9. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

10. Defendant made representations to Plaintiff concerning payment in accordance with the health benefit plan or Summary Plan Description ("SPD").

11. Defendant failed to comply with the terms of the Summary Plan Description.

12. Plaintiff reasonably relied upon the representations made by the SPD.

13. As a result of Defendants actions, Plaintiff has been damaged in an amount of $26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

FOURTH CAUSE OF ACTION
(Breach of Duty of Good Faith and Fair Dealing)

14. Plaintiff repeats and restates the allegations in the preceding paragraphs of the Complaint as if fully set forth at length herein.

15. Defendants owed Plaintiff an obligation to act in good faith and deal fairly with him regarding the terms of the SPD.

16. By engaging in the misconduct alleged herein, Defendants breached their duty of good faith and fair dealing, which has damaged and continues to damage Plaintiff.

17. As a result of Defendants actions, Plaintiff has been damaged in an amount of $26,585.82 for date of service September 11, 2019, cost of suit, attorneys' fees, plus interest, thereon and any other relief as the Court deems just and equitable under the circumstances.

WHEREFORE, Plaintiff demands judgment against Defendants, as follows:

a. For an Order directing Defendant to pay to Plaintiff $26,585.82 for date of service (DOS);

b. For compensatory damages and interest;

c. For attorney's fees and costs of suit, if allowed by the Agreement; and

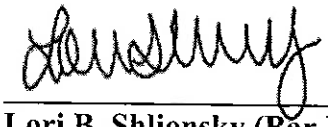
d. For such other and further relief as the court may deem just and equitable.

[Signature block continued on next page.]

Dated: July 29, 2022

Respectfully submitted,

CALLAGY LAW, PC



Lori B. Shlionsky (Bar Id. 205322017)
650 From Road, Suite 240
Paramus, New Jersey 07652
Telephone: (201) 261-1700
Facsimile: (201) 549-6237
E-mail: lshlionsky@callagylaw.com
Attorney for Plaintiff

TRIAL COUNSEL DESIGNATION

Lori B. Shlionsky, Esq., is hereby designated as Trial Counsel in the above matter.

R. 4:5-1(b)(2) CERTIFICATION

Pursuant to R. 4:5-1(b)(2), I hereby certify that the matter in controversy is not the subject of any other action pending in any court, is not the subject of a pending arbitration proceeding and is not the subject of any other contemplated action or arbitration proceeding, except as may be set forth below:

None.

I further certify that I know of no non-parties who should be joined in the action pursuant to R. 4:28, or who may be subject to joinder pursuant to R. 4:29-1(b) because of potential liability to any party on the basis of the same transactional facts, except as may be set forth below:

None.

Respectfully submitted,

CALLAGY LAW, PC

Lori B. Shlionsky (Bar Id. 205322017)
650 From Road, Suite 240
Paramus, New Jersey 07652
Telephone: (201) 261-1700
Facsimile: (201) 549-6237
E-mail: lshlionsky@callagylaw.com
Attorney for Plaintiff

Cigna Health and Life Insurance Co.

Coverage Effective Date: 01/01/2015

[redacted]

Seton Hall University

Insured

MultiPlan

Network Savings Program

Open Access Plus

No Referral Required	
PCP Visit	$20
Specialist	$20
Inpatient Hosp	$0
Hospital ER	$75
Urgent Care	$35
Network Coinsurance:	
In	100%/0%
Out	70%/30%

ay be asked to present this card when you receive care. The card does not guarantee cov
ust comply with all terms and conditions of the plan. Willful misuse of this card is consider

IENT ADMISSION AND OUTPATIENT PROCEDURES:

Network provider must call the toll-free number listed below to pre-certify the above service
to your plan documents for your pre-certification requirements. Failure to do so may affect
s. In an emergency, seek care immediately, then call your primary care doctor as soon as
e for further assistance and directions on follow-up care within 48 hours.

aims to:

P.O. Box 182223, Chattanooga, TN 37422-7223

mer Service/Network Provider Services: 1-800-244-6224

courage you to use a PCP as a valuable resource and personal health advocate.

AWAY FROM H

MEDICAL RECORD
STATUS: UNSIGNED

Progress Notes

NOTE DATED: 09/11/2019 12:34
LOCAL TITLE: OR:OPERATIVE REPORT
VISIT: 09/11/2019 08:33 SAMEDAY SURGERY M

[redacted]

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Lumbar spinal stenosis.

POSTOPERATIVE DIAGNOSIS: Lumbar spinal stenosis.

PROCEDURES PERFORMED: L3 laminectomy, L4 laminectomy, L5 laminectomy, S1 partial laminectomy.

SURGEON: Joshua Rovner, MD

SURGICAL ASSISTANT: Brian Bannister, MD

ANESTHESIA: General endotracheal.

POSITION: Prone.

COMPLICATIONS: None.

CONDITION: Stable to PACU.

PREOPERATIVE INDICATIONS: Ms. Williams is a 63-year-old female with severe radiating back and leg?pain with neurogenic claudication. She was found to have spinal stenosis at L3-4, L4-5 and L5-S1. She failed an extensive course of nonsurgical treatment and was indicated for the above procedure, which was deemed to be medically necessary. Risks, benefits, and alternatives of the procedure were discussed with this patient at length. Risks included, but not limited to, bleeding, infection, wound dehiscence, nerve?damage, vascular? damage, anesthesia?complications, continued pain, paralysis and death. The patient understood the risks, benefits and alternatives, and agreed to undergo the above procedure.

DESCRIPTION OF THE PROCEDURE: On the date of surgery, the patient was seen and examined in the preop holding area. Risks, benefits, and alternatives were again discussed and consent was signed and witnessed. All questions were answered. No?guarantees were given. The patient was subsequently brought into the operating room and placed supine on the stretcher. General endotracheal anesthesia was induced and begun without difficulty. IV antibiotics were given prior to incision. Next,?the?patient was placed prone on a Wilson frame. Eyes were protected. Arms?were protected. All bony prominences were carefully padded. Low back was prepped and draped in a usual sterile fashion. Next, an incision was made from L3-4 to L5-S1. Careful dissection was made down to the lumbar fascia which was split in line with the incision. Subperiosteal dissection was made from L3 through S1 and deep? retractors were placed. Next, Leksell rongeurs as well as high-speed burrs and Kerrison rongeurs were used to create a central laminectomy of L3.

** THIS NOTE CONTINUED ON NEXT PAGE **

[redacted]

MEDICAL RECORD
STATUS: UNSIGNED

Progress Notes

09/11/2019 12:34 ** CONTINUED FROM PREVIOUS PAGE **

Bilateral?subarticular decompressions were done also using a Kerrison rongeur removing the ligamentum flavum and decompressing bilateral nerve roots. Next,? the?exact?same procedure was done at L4, the exact same procedure was done at L5 and the cranial portion of S1 was taken in a way of partial laminectomy of S1. Central?decompression and bilateral subarticular and foraminal decompressions were done at all three levels L3-4, L4-5 and L5-S1. The dura was completely decompressed at this procedure. There was no evidence of dural tear or complications. There was no significant bleeding. A deep medium Hemovac drain was placed and 1 gm of vancomycin powder was placed in deep subcutaneous tissues as an antibiotic?prophylaxis. Next, fascia was closed using interrupted Vicryl sutures and adipose as well as skin was closed in a multilayered fashion. The drain was placed to suction. Dermabond, Steri-Strips and clean dry sterile dressing were placed. The?patient was placed supine and awoken from general endotracheal anesthesia in stable condition having tolerated the procedure well.

Postoperative plan will be for gentle activities as tolerated, pain control, early?mobilization and close followup.

Joshua Rovner, MD

PTC/84
JOB: 0911-061
DDT: 09/11/2019 12:34
TDT: 09/12/2019 05:09

DRAFT COPY - DRAFT COPY -- ABOVE NOTE IS UNSIGNED-- DRAFT COPY - DRAFT COPY

[redacted]

Cigna Health and Life Insurance Company
SCRANTON CLAIM OFFICE
P.O. BOX 182223
CHATTANOOGA TN 37422-7223

Cigna Health and Life Insurance Company

SETON HALL UNIVERSITY

Dr. Bannister (Asst.)

[redacted]

Date through which claims were processed:
04/02/2020

Payloc
768

How to Contact Us

Mail to the return address in upper left corner of this page

Phone: (800) 244-6224

MONMOUTH CNTY PAIN MGMT
432 OCEAN BLVD UNIT 201
LONG BRANCH NJ 07740-5681

Provider Explanation of Medical Payment

Understanding this Benefits Statement

This page provides a summary of the payments made this period.

The accompanying pages give more detail on the claims we processed for this period. Please review both the front and back of each page to see how the benefit amounts in the Provider Explanation of Medical Payment Report were determined.

In the event a claim is denied.....

Rights of Review and Appeal - For Physician or Health Care Provider

If you have questions or disagree with the payment identified on this Explanation of Medical Payment Report, you may ask to have it reviewed.

If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

- Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
- If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).
- Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
- Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- You are entitled to receive free upon request access to , and copies of, all documents, records and other information relevant to your claim for benefits.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Payment Summary

Check Number: 00397878477	Check Amount: $623.88	Check Date: 04/02/2020

G2434D 07-21-2017 PROCLAIM Medical Provider EOP

Detach on Perforation Below - Please Cash Promptly

Cigna Health and Life Insurance Company

SETON HALL UNIVERSITY

CHECK #
00397878477
73-27/421

Payloc 768	DATE	Provider #	
	04/02/2020	464029458	0010

SIX HUNDRED TWENTY THREE DOLLARS AND 88 CENTS

Pay to the Order of
MONMOUTH CNTY PAIN MGMT
432 OCEAN BLVD # 201
LONG BRANCH NJ 07740-5681

Dollars $ ********623.88

Void If Not Cashed Within 180 Days

FIFTH THIRD BANK
NORTHERN, KENTUCKY
3334085

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW.

G2434D 07-21-2017 PROCLAIM Medical Provider EOP

⑈397878477⑈ ⑆042100272⑆ 7481590250⑈

Provider Explanation of Medical Payment Report

Cigna.

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
464029458 0010	MONMOUTH CNTY PAIN MGMT	04/02/2020		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG/ Per Diem / APC Type	DRG/ Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
	Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.														
[redacted]															
1	09112019	63047		95000.00		397.38	94602.62					0.00	0.00	397.38	A0
2	09112019	63048		34500.00		75.50	34424.50					0.00	0.00	75.50	A0
3	09112019	63048		34500.00		75.50	34424.50					0.00	0.00	75.50	A0
4	09112019	63048		34500.00		75.50	34424.50					0.00	0.00	75.50	A0
5	09112019	76000	76000	2400.00			2400.00					0.00	0.00	0.00	A1
	TOTAL			200900.00		623.88	200276.12							623.88	

THE $500 OUT OF NETWORK INDIVIDUAL DEDUCTIBLE HAS BEEN SATISFIED FOR 2019
THE $2,000 OUT OF NETWORK INDIVIDUAL 'OUT-OF-POCKET LIMIT' HAS BEEN REACHED FOR 2019
THE $1,000 IN NETWORK INDIVIDUAL 'OUT-OF-POCKET LIMIT' HAS BEEN REACHED FOR 2019
$156,930.28 HAS BEEN APPLIED TO THE UNLIMITED ALL MEDICAL BENEFITS INDIVIDUAL LIFETIME MAXIMUM
$500.00 HAS BEEN APPLIED TOWARDS THE $1,000 OUT OF NETWORK FAMILY DEDUCTIBLE FOR 2019
$2,000.00 HAS BEEN APPLIED TOWARDS THE $4,750 OUT OF NETWORK FAMILY 'OUT-OF-POCKET LIMIT' FOR 2019
THE $2,000 IN NETWORK FAMILY 'OUT-OF-POCKET LIMIT' HAS BEEN REACHED FOR 2019

BALANCE..... $197,876.12

PAYMENT OF $623.88 TO MONMOUTH CNTY PAIN MGMT

DLP AK4

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) FOR OUT-OF-NETWORK SERVICES, CIGNA WILL REIMBURSE YOU UP TO A SET MAXIMUM AMOUNT (KNOWN AS MAXIMUM REIMBURSABLE CHARGE IN YOUR PLAN BOOKLET). YOUR HEALTH CARE PROFESSIONAL MAY BILL YOU FOR ANYTHING ABOVE THIS AMOUNT.

A1) THE PROCEDURE IS DISALLOWED BECAUSE THIS SERVICE OR A COMPONENT OF THIS SERVICE WAS PREVIOUSLY BILLED BY ANOTHER HEALTH CARE PROFESSIONAL.

Seton Hall University

Table of Contents

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Cigna

rcial Plan Provisions

rvices Available in Conjunction With Your Medical

ss

e Management

Important Notice

Notice of Grandfathered Plan Status

Cigna

Cigna

[illegible]

Cigna

Cigna

Eligibility - Effective Date

Employee Insurance

Eligibility for Employee Insurance

Cigna

Important Information About Your Medical Plan

Cigna

Cigna

Open Access Plus Medical Benefits
The Schedule

For Network Care Providers

Coinsurance

Copayments Deductible

Out of Pocket Expenses

Coordination of Benefits and Out of Pocket Maximums

Inpatient Surgical Reduction

Cigna

Open Access Plus Medical Benefits
The Schedule

Surgical Surgeon and/or Surgeon Charges

Scheduled Surgeon

The maximum amount payable will be limited to charges made for an accepted surgical procedure that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reasonable Charges. For purposes of this [illegible] allowable charge means the amount payable to the surgeon prior to any [illegible] or coinsurance or deductible amount.

Co-Surgeons

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reasonable Charges.

[illegible]	[illegible]	[illegible]
Lifetime Maximum		Unlimited
The Percentage of Covered Expenses the Plan Pays Note: "No charge" means an insured person is not required to pay for a service.	100%	70%

Cigna

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK

Maximum Reimbursable Charge
Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or
A policyholder-selected percentage of a schedule developed by the Insurance Company that is based upon a methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. (The Insurance Company may apply a rate higher than the Medicare allowable rate.)
A Medicare based schedule will not be used in determining the Maximum Reimbursable Charge for:
• charges made by providers not participating in Medicare or that do not submit their Medicare ID with the claim;
• Covered Services for which Medicare has not established a rate; and
• the following Covered Services until such time as the Insurance Company has implemented a Medicare-based schedule for them: certain ambulance services, treatment of end stage renal disease, Home Health Care, Skilled Nursing Facility, and inpatient rehabilitation.
In these situations:
• the Maximum Reimbursable Charge is determined based on the lesser of:
  • the provider's normal charge for a similar service or supply; or
  • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.
	Not Applicable	200%

Cigna

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Note: The insured person will pay the difference between the provider's normal charge and the Maximum Reimbursable Charge in addition to any applicable deductibles, copayments and coinsurance.		
Calendar Year Deductible		
Individual	Not Applicable	$[illegible] per person
Family Maximum	Not Applicable	$[illegible] per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Out-of-Pocket Maximum		
Individual	$1,000 per person	$[illegible] per person
Family Maximum	$2,000 per family	$[illegible] per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	No charge after [illegible] per office visit copay	[illegible]% after plan deductible
Specialty Care Physician's Office Visits	No charge after [illegible] Specialist per office visit copay	[illegible]% after plan deductible
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company		
Surgery Performed in the Physician's Office	No charge after the [illegible] PCP or [illegible] Specialist per office visit copay	[illegible]% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge	No charge
Allergy Treatment/Injections	No charge after either the [illegible] PCP or [illegible] Specialist per office visit copay or the actual charge, whichever is less	[illegible]% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	[illegible]% after plan deductible
Preventive Care (according to USPSTF recommendations) – all ages		
• Cholesterol screenings for lipid disorders • Immunizations (including lead poisoning screening for children, medical follow-up care and treatment) and physical examinations • Pneumococcal and influenza vaccinations • Alcohol misuse and behavioral counseling interventions • Tobacco use screening of adults and tobacco cessation interventions	No charge	[illegible]% after plan deductible
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	No charge	[illegible]% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's copay & benefit based on place of service	Subject to the plan's copay & benefit based on place of service

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Facility Services		
Other Private Rooms and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Intensive Care Unit (ICU)	Limited to the negotiated rate	Limited to the [illegible] daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	[illegible]	[illegible] after plan [illegible]
Inpatient Hospital Physician Visits/Consultations	[illegible]	[illegible] after plan [illegible]
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	[illegible]	[illegible] after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	[illegible]	[illegible] after plan deductible

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[illegible]	[illegible]	[illegible]
Emergency and Urgent Care Services		
Physician's Office Visit	No charge after the $[illegible] PCP or $[illegible] Specialist per office visit copay	No charge after the $[illegible] PCP or $[illegible] Specialist per office visit copay
Hospital Emergency Room	No charge after $[illegible] per visit copay* *waived if admitted	No charge after $[illegible] per visit copay* *waived if admitted
Outpatient Professional Services (radiology, pathology and ER physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	No charge after $[illegible] per visit copay* *waived if admitted	No charge after $[illegible] per visit copay* *waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)	No charge	No charge
Ambulance	100%	100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: [illegible] days combined	100%	[illegible]% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	No charge after the $[illegible] PCP or $[illegible] Specialist per office visit copay	[illegible]% after plan deductible
Outpatient Hospital Facility	100%	[illegible]% after plan deductible
Independent X-ray and/or Lab Facility	100%	[illegible]% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CATScans and PET Scans)		
Physician's Office Visit	No charge	50% after prog deductible
Outpatient Facility	10%	50% after plan deductible
Independent Facility	10%	50% after plan deductible
Outpatient Short Term Rehabilitation Therapy Calendar Year Maximum 60 days for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.	No charge after the first $15 per visit Maximum per office visit copay Note: Outpatient Short Term Rehab visits apply against visits allowed in network calendar year limit	50% after plan deductible
Chiropractic Care Calendar Year Maximum 30 days Physician's office visit	No charge after the first $15 per visit Maximum per office visit copay	50% after plan deductible
Home Health Care Calendar Year Maximum 100 days (includes intermittent private nursing when approved as Medically Necessary)	10%	50% after plan deductible
Hospice Inpatient Services Outpatient Services Home Hospice Care (Inpatient Care)	10% 10%	50% after plan deductible 50% after plan deductible

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Benefits Description	**In-Network**	**Out-of-Network**
Maternity Care Services		
Abortion		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Physician's Office Visit (Tests, Counseling) Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUD)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office. Includes: Surgical Sterilization Procedures for Vasectomy/Tubal Ligation	No charge after the $20 PCP or $20 Specialist per office visit copay	70% after plan deductible
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition • Testing performed specifically to determine the cause of infertility • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition) • GIFT Coverage will not be provided for the following services, which do not restore fertility or correct an infertility condition: • Artificial Insemination, In-vitro, ZIFT, Embryo Transfer, Intracytoplasmic Sperm Injection		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $20 PCP or $20 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	100%	70% after plan deductible
Outpatient Facility	100%	70% after plan deductible
Physician's Services	100%	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate non-experimental transplants		
Physician's Office Visit	No charge after the $15 PCP or $25 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	100% of Eligible Charges, otherwise 100%	70% after plan deductible
Physician's Services	100% of Eligible Charges, otherwise 100%	70% after plan deductible up to specific organ transplant maximum Heart $1,500,000 Liver $250,000 Bone Marrow $150,000 Heart/Lung $1,500,000 Lung $300,000 Pancreas $75,000 Kidney $60,000 Kidney/Pancreas $85,000
Lifetime Travel Maximum Unlimited	No charge	No charge
Durable Medical Equipment Calendar Year Maximum Unlimited	100%	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum Unlimited	No charge	70% after plan deductible
Hearing Aid Maximum One hearing aid for each hearing impaired ear every 24 months for a dependent child under age 18		
Diabetic Equipment Calendar Year Maximum Unlimited	100%	70% after plan deductible
Nutritional Evaluation Calendar Year Maximum 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes		
Physician's Office Visit	No charge after the $15 PCP or $25 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	100%	70% after plan deductible
Outpatient Facility	100%	70% after plan deductible
Physician's Services	100%	70% after plan deductible

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Dental Care		
Physician's office visit		
Inpatient Facility		
Outpatient Facility		
Physician's services		
Obesity Bariatric Surgery		
Note:		
Physician's office visit		
Inpatient Facility		
Outpatient Facility		
Physician's Services		
Note:		
Routine Foot Disorders		
Treatment Resulting From Life Threatening Emergencies		

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Mental Health		
Inpatient	100%	[illegible]
Outpatient (includes individual, group and intensive outpatient)		
Physician Office Visit	$35 per visit copay	[illegible]
Outpatient Facility	100%	[illegible]
Substance Abuse		
Inpatient	100%	[illegible]
Outpatient (includes individual and intensive outpatient)		
Physician Office Visit	$35 per visit copay	[illegible]
Outpatient Facility	100%	[illegible]

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...ges Plus Medical Benefits

...ification Requirements - Out of Network

- You and Your Dependents
- Admission Certification[illegible] required from Review for ...ospital Confinement

- Admission notification (PAC) and Continued Stay ... (CSR) prior to the person's ... the Medical ... events and length of a Hospital ... Confinement when ... a Dependent requires ... in a Hospital

... registered bed patient, except for ... have emergency ...

... a Partial Hospitalization for the treatment of Mental Health or Substance Abuse

... Mental Health or Substance Abuse Residential Treatment Services

... you or your Dependent should require PAC prior to any non-urgent treatment in a Hospital described above. In the ... of an emergency admission, you should contact the ... Organization by the end of the first scheduled work ... after the admission or as soon as reasonably possible. For ... admissions due to pregnancy, you should call the Review ... by the end of the third month of pregnancy. CSR ... will be requested, prior to the end of the certified length ... for continued Hospital Confinement. The results of the ... will be communicated to you, the attending Physician and ... Cigna.

... Expenses incurred will be reduced by 50% for ... charges made for any outpatient admissions to the ... unless PAC is received ... prior to the date of ... or in the case of an emergency admission, by the ... of the first scheduled work day after the date of ... Services provided after this deadline will be accepted ... the penalty waived, provided notification was made ... as reasonably possible.

... Expenses incurred for which benefits would ... payable under this plan for the charges listed ... will be reduced by 50%:

... charges for first and third ... for which PAC was ... which are made for ... to the number of days certified through PAC or CSR; and

... Hospital charges for treatment listed above for which PAC was requested, but which were not certified as ... Necessary.

... will not participate through a ... Plan or a Preferred Organization with which you are ... enrolled.

... Expenses incurred for which payment is ... by the terms of both above will not be considered ... expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

...patient Certification Requirements - Out of Network

... certification refers to the process used to certify ... Medical ... of outpatient diagnostic testing and ... procedures, including, but not limited to, those ... and services when performed in an outpatient ... setting (except Facility). Other Health Care Facilities ... Physician's office. You or your Dependent should call for ... prior to the start of your ... and ... of ... certification is required prior to any outpatient ... testing or procedure. The results of the review will ... communicated to you, the attending Physician and Cigna. ... of the Review Organization having received the ... for certification, Outpatient Certification is performed ... a utilization review program by a Review ... Organization with which your ... contracted. Outpatient ... must only be requested for ... procedures or services ... and should be requested by you or ... Dependent at least four working days (Monday through ... prior to having the procedure performed or the service rendered.

... Expenses incurred will be reduced by 50% for ... charges made for any outpatient diagnostic testing or ... procedure performed unless Outpatient Certification is ... prior to the date the testing or procedure is ... performed.

... Expenses incurred will be reduced by 50% for ... charges made for outpatient diagnostic testing or procedures ... which Outpatient Certification was performed, but which ... not certified as Medically Necessary.

... cases, those expenses incurred for which payment is ... by the terms of both above will not be considered ... expenses incurred for the purpose of any other part of this ... except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures

... including, but not limited to:

- Advanced (sleep) imaging ... CT Scans, MRI, MRA, ... PET scans
- Chemotherapy

...

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[illegible]

eneral Limitations

[illegible]

Personal Injury Protection (PIP) or Out-of-State Automobile Insurance Coverage (OSAIC)

[illegible]

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ination of Benefits

CASE NOTE: If you are covered by more than one with benefit plan, you should file all your claims with ch plan and provide each plan with information garding the other plans under which you are covered.

ypose of This Provision

covered person may be covered by health benefits or vices by more than one Plan. For example, he or she may be covered by this policy as an Employee and by another plan as dependent of his or her spouse. If he or she is covered by re than one Plan, this provision allows Cigna to coordinate ts Cigna pays or provides with what another Plan owes or vides. This provision sets forth the rules for determining ich is the primary plan and which is the secondary plan. ordination of benefits is intended to avoid duplication of nefits while at the same time preserving certain rights to overage under all Plans under which the covered person is covered.

finitions

e words shown below have special meanings when used in s provision. Please read these definitions carefully throughout this provision. These defined terms appear with a capital letter throughout.

ow this Expense. The charge for any benefit, any service, ply or other item of expense for which the covered person holds when the health care service, supply or other item of pense is covered at least in part under any of the Plans. ept where a statute requires another definition, as otherwise stated below.

his new policy is coordinating benefits with a Plan that what benefits can be for dental care. Should that group plan go to hearing aids. Allowable Expense is limited to the ost of expense.

you will not consider the difference between the cost of a vate hospital room and the cost of a semi-private room in Allowable Expense unless the stay in a private room is edically necessary and Appropriate.

his policy is coordinating benefits with a Plan that ides coordination of benefits, you may be required to give Cigna certain information, including certain facts about

Appropriate, as it relates to a Hospital Confinement or Treatment, applies as an Allowable Expense.

Claim Determination Period. It is a calendar Plan or any portion of a calendar Plan during which a covered person is covered by this policy **and** at least one other Plan and may be one or more Allowable Expenses under such plans.

Plan. Coverage with which coordination of benefits is allowed. Plan includes:

- group insurance and group service contracts including insurance continued pursuant to Federal or State continuation law;
- self-funded arrangements of group or group-type coverage including insurance continued pursuant to a Federal or State continuation law;
- group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- group hospital indemnity benefit amounts that exceed $150.00 per day;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as an excess or other private insurance plan or other governmental plan.

Plan does not include:

- individual or family insurance contracts or subscriber contracts;
- individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- a group or group-type coverage where the cost of coverage is paid solely by the covered person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- a group hospital indemnity benefit amounts of $150.00 per day or less;
- school accident type coverages;
- a hospital cash only benefit.

Primary Plan. A Plan whose benefits for a covered person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either one of the following rules apply:

- The Plan has no order of benefit determination rules, or its rules differ from those contained in this provision, regardless of whether or not it pays its benefits first; or
- All Plans which cover the covered person use rules of benefit determination rules consistent with those contained

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Payment of Benefits

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Termination of Insurance

Employees

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Federal Requirements

Medical Benefits Extension Upon Policy Cancellation

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in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

Loss of eligibility for other coverage (excluding continuation coverage). If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of Dependent status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

Termination of Employer contributions (excluding continuation coverage). If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

Exhaustion of COBRA or other continuation coverage. Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or other continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

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Change of Status

Court Order

Medicare or Medicaid Eligibility Entitlement

Change in Cost of Coverage

Changes in Coverage of Spouse or Dependent Under other Employer's Plan

Eligibility for Coverage for Adopted Children

Coverage for Maternity Hospital Stay

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Statement of Rights

Your Information About Your Plan and Benefits

Your Group Health Plan Coverage

What Happens If Plan Fiduciaries

Prior Your Rights

Assistance with Your Questions

Notice of an Appeal or a Grievance

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[illegible] You Have A Concern Or Complaint

[illegible]

[illegible] and Administrative Appeals Regarding [illegible] Benefits, Quality of Care and Services [illegible] with Member Services

[illegible]

Level One Appeal

[illegible]

Level Two Appeal

[illegible]

Appeal to the State of New Jersey

[illegible]

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[illegible]

[illegible]

Definitions

[illegible]

Bed and Board

[illegible]

Biologically Based Mental Illness

[illegible]

Charges

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]ntal Health Benefits

[illegible] Mental Health benefits [illegible] plan, expenses incurred with respect to covered services in [illegible] the following categories: [illegible] services, [illegible] mental health and substance use disorder services, [illegible] behavioral health treatment, prescription drugs, [illegible] and habilitative services and devices, laboratory [illegible] preventive and wellness services and chronic disease management and pediatric services, including oral and vision [illegible].

[illegible]

[illegible]pense Incurred

[illegible] expense is incurred when the service or the supply for which it is incurred is provided.

[illegible]

[illegible]ee-Standing Surgical Facility

[illegible] term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an inpatient basis; and

- it is licensed in accordance with the laws of the appropriate legally authorized agency.

[illegible]

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

[illegible]

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

[illegible]

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

[illegible]

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Review Organization

Sickness – For Medical Insurance

Skilled Nursing Facility

Cigna

CIGNA
PO BOX 182223

CHATTANOOGA TN 37422

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

XXX PICA

PICA XXX

CARRIER

[redacted]

PATIENT AND INSURED INFORMATION

to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M48061 B. M5416 C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 11 19	09 11 19	22		63047	80	AB	95000 00	1		NPI	
2 09 11 19	09 11 19	22		63048	80	AB	3450000	1		NPI	
3 09 11 19	09 11 19	22		63048	80 59	AB	3450000	1		NPI	
4 09 11 19	09 11 19	22		63048	80 59	AB	3450000	1		NPI	
5 09 11 19	09 11 19	22		76000	80 26 59	AB	2400 00	1		NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
464029458 ☐ ☒

26. PATIENT'S ACCOUNT NO.
23047

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 200900 00

29. AMOUNT PAID $ 623 88

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
BRIAN A BANNISTER, MD
SIGNED 05 21 20 DATE

32. SERVICE FACILITY LOCATION INFORMATION
HUDSON REGINAL HOSPITAL
55 MEADOWLAND PKWY
SECAUCUS NJ 070942305
a. b.

33. BILLING PROVIDER INFO & PH # (732) 4932040
Monmouth County Pain Management
432 OCEAN BLVD UNIT 201
LONG BRANCH NJ 077405681
a. b.

PHYSICIAN OR SUPPLIER INFORMATION

Cigna
Appeals
PO Box 188011
Chattanooga, TN 37422

June 12, 2020

Monmouth County Pain Management
Attn: Purvi Joshi
432 Ocean Blvd. Unit 201
Long Branch NJ 07740

[redacted]

Dear Monmouth County Pain Management,

Your request for a Single Level Provider Payment Appeal for the service referenced above has been completed. After reviewing your request, we have decided to uphold the original decision.

We use a methodology similar to Medicare to determine reimbursement for the same or a similar service within a geographic market. Because we don't have any information that supports a reason to pay more than the Maximum Reimbursable Charge, we won't pay anything more towards this claim.

Additionally, your request for a copy of the benefit plan and all records relevant to the claim determination has been forwarded to the appropriate area for review and response.

This is the final internal level of appeal.

If you are not satisfied with this decision, you may be eligible to seek resolution through a state-contracted arbitration organization (AO), under the provisions of the New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA). This process is

called the New Jersey Program for Independent Claims Payment Arbitration (PICPA), and the state-contracted arbiter is MAXIMUS, Inc.

To request a PICPA review, you must complete a MAXIMUS application accessible online at www.njpicpa.maximus.com, and submit the application, together with required review and arbitration fees.

If you wish to submit applications by mail, use the contact information provided on the MAXIMUS website at www.njpicpa.maximus.com. Supporting documentation may be submitted online, faxed or mailed using the case number generated through the online submission process. Fees must be submitted by mail at this time and must also include the case number. An application for arbitration will not be considered until the required application fees are received.

If you have any questions, please feel free to call Cigna at 1-800-882-4462. A representative will be happy to assist you.

Sincerely,

Vonda S.
Appeals Processor

Civil Case Information Statement

Case Details: MONMOUTH | Civil Part Docket# L-002063-22

Case Caption: MONMOUTH COUNTY PAIN MANAGEME VS CIGNA HEALTH A
Case Initiation Date: 07/29/2022
Attorney Name: LORI B SHLIONSKY
Firm Name: CALLAGY LAW
Address: 650 FROM RD STE 565 PARAMUS NJ 07652
Phone: 2012611700
Name of Party: PLAINTIFF : MONMOUTH COUNTY PAIN MANAGEMEN
Name of Defendant's Primary Insurance Company (if known): Unknown

Case Type: CONTRACT/COMMERCIAL TRANSACTION
Document Type: Complaint
Jury Demand: NONE
Is this a professional malpractice case? NO
Related cases pending: NO
If yes, list docket numbers:
Do you anticipate adding any parties (arising out of same transaction or occurrence)? NO
Does this case involve claims related to COVID-19? NO

Are sexual abuse claims alleged by: MONMOUTH COUNTY PAIN MANAGEMEN? NO

THE INFORMATION PROVIDED ON THIS FORM CANNOT BE INTRODUCED INTO EVIDENCE

CASE CHARACTERISTICS FOR PURPOSES OF DETERMINING IF CASE IS APPROPRIATE FOR MEDIATION

Do parties have a current, past, or recurrent relationship? NO

If yes, is that relationship:

Does the statute governing this case provide for payment of fees by the losing party? NO

Use this space to alert the court to any special case characteristics that may warrant individual management or accelerated disposition:

Do you or your client need any disability accommodations? NO
If yes, please identify the requested accommodation:

Will an interpreter be needed? NO
If yes, for what language:

Please check off each applicable category: Putative Class Action? NO **Title 59?** NO **Consumer Fraud?** NO

I certify that confidential personal identifiers have been redacted from documents now submitted to the court, and will be redacted from all documents submitted in the future in accordance with *Rule* 1:38-7(b)

07/29/2022
Dated

/s/ LORI B SHLIONSKY
Signed